

## MISSOURI DIVISION OF PUBLIC HEALTH AND WELFARE — STANDARD CERTIFICATE OF DEATH

-62-001509

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No.

Primary Registration District No. 1002 Registrar's No.

653

STATE FILE NUMBER

FILED FEB 15 1962

1. PLACE OF DEATH

a. COUNTY

Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo

b. COUNTY

Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR  
TOWN

Kansas City

Length of stay in 1b

40 yrs

c. CITY  
OR  
TOWN

Kansas City

Inside Limits  
Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR  
INSTITUTION

D O A St Mary's Hosp

Inside Limits  
Yes ☒ No ☐d. STREET  
ADDRESS

4715 Gladstone Blvd.

Reside on Farm  
Yes ☐ No ☒3. NAME OF DECEASED  
(Type or print)First  
ELLISMiddle  
BLast  
BOOTH4. DATE  
OF  
DEATHMonth  
2/3/62

Day

Year

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

3-24-1899

9. AGE (last birthday)

62

IF UNDER 1 YEAR

IF UNDER 24 HR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Car Inspector

10b. KIND OF BUSINESS OR INDUSTRY

K C So. Ry

11. BIRTHPLACE (City and state or country)

Richmond, Mo

12. CITIZEN OF WHAT COUNTRY

U S A

13a. FATHER'S NAME

Joseph J Booth

13b. MOTHER'S MAIDEN NAME

Mable Burke Booth

14. NAME OF HUSBAND OR WIFE

Lucille Bates Booth

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)  
no no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Lucille Booth, 4715 Gladstone

18. CAUSE OF DEATH (Enter only one cause per line)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

DUE TO (b)

DUE TO (c)

Coronary Occlusion

INTERVAL BETWEEN  
ONSET AND DEATHPART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal  
disease condition given in PART I (a)PART III. If deceased was female was  
there a pregnancy in last 90 days.☐ Yes☐ No☐ Unknown19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF  
INJURYHour  
a.m.  
p.m.

Month, Day, Year

20d. INJURY OCCURRED  
WHILE AT WORK ☐  
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,  
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_, and last saw her  
him alive on \_\_\_\_\_.  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. MANNER OF BURIAL  
(Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Sheil Funeral Home

K.C. Mo

2-5-62

Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

SHOULD READ

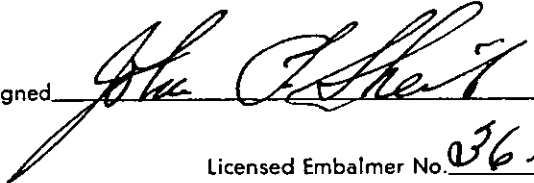
H. H. Owens

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 03625

P. O. Address H. C. Mills

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.